Idaho Interagency Committee on Substance Abuse Prevention and Treatment Meeting

April 18, 2007

Attendees: Debbie Field, Delana Harper, Shane Evans, Kelly Jo Hilliard, Kathleen Allyn, John Kirsch, Sharon Harrigfeld, Jerry Russell, Paul Carroll, Patty Tobias, Amy Castro, Amy Holly-Priest, Jean Woodward, Sarah Nye, Dave Walker, Brad Alvaro, Jim Clark, Shelley McCoshum, Bev Ashton, Melanie Curtis, Paul Carroll, Bethany Gadzinsky

Absent: Dick Armstrong, Brent Reinke

Minutes:

Agenda Item #1 – RFP Pathway Progress Report/Discussion

Debbie Field – Subcommittees formed to take care of writing RFP components. Need RFP to be finished by the end of March.

Sharon Harrigfeld – Review of RFP for clarity of needs underway. Going to require someone from Dept. of Admin to attend subcommittee meetings to define the 'how' on the RFP while Sharon's group defines the 'what'. More numbers will help (i.e. number of juveniles going into system and being evaluated by the Gain I and Gain Q). The pathway consists of the following:

Adolescent Criminal
Adolescent Non-criminal
Felony Offender
Pregnant Female Users
IV Drug Users

The subcommittees will provide the pathways and the definitions. Goal is to have the report by May 16, 2007. RFP to hit by June 1, 2007 and be awarded by October 1, 2007 Looking at having either 1 or 2 RFP's: one for intake and one for managed care. Splitting these out will help the program/tool be more manageable and issues will be easier to address if taken care of separately.
Gain I takes about 120 minutes to complete. This should be completed within 2 weeks for kinds in juvenile detention and no longer than 3 weeks for all others.

Shane Evans – Concerned with time management on PSI. Sharon assured that this is being discussed with the judges for the writing of the RFP.

Debbie Field – Pointed out that right now, 100% of kids get treatment. 75% of those just need intervention while the remaining 25% are abusing already and/or addicted and need treatment. So intervention at the earlier stage would be cheaper. The treatment costs @ $4000, while intervention would cost @1500. A cost saving of $2500. Sharon pointed out

that we are currently forcing kids into a treatment program and that H&W needs to fund intervention. Debbie said that we could find the money to fund the intervention program from the savings on not forcing everyone into treatment when it may not be what is needed. Sharon said they are currently working on that issue. Debbie then explained about the phases of the process of assessment – adults, kids, mental health and Spanish need to be qualifications of the tool used.

Shane Evans – Stated that for IDOC (corrections) the Gain Q would be used.

Sharon Harrigfeld – Pointed at that the misdemeanor pathway includes DUI. They are taking baby steps toward DUI evaluations using the Gain Q.

Kathleen Allyn – Discussed the time period to move after Gain I to then do a mental health evaluation and the Gain Q. The Gain Q only has indicators while the Gain I does more evaluating of mental health if a mental health evaluation needs to be done. Sharon said that she will take this issue to the subcommittee.

Shane Evans – Asked if Gain I leads to the need to do a mental health evaluation, will there still be time to complete it. Currently there is only 4-6 weeks available for corrections to get all of this completed. Patty said that they are not currently anticipating moving away from this timeline. A judge can ask fro more mental health assessment. Patty also pointed out that this should not cause the RFP process to slow down. Sharon assured that they would be mindful of this while writing the RFP.

Jerry Russell – Brought up the need for an adolescents family to be assessed to prevent relapse when the child is returned back to their family. And for the family to receive some sort of training and/or social skills for the child's ability to continue on the path after the program is completed. Sharon said that this is part of the social history process that is completed on each child and is ongoing. Patty pointed out that by statute and in practice, the family is kept involved in the whole process. Jerry then asked if during the 1st assessment done, is there a parallel tract for the child and for the family. Patty pointed out that yes, the family is involved. Jean stated that the program has the intent of building community and to assist families to prevent relapse. Sharon said they are working on making sure that skills are provided or made aware of for families to help kids.

Agenda Item #2 – Agency Reports

Debbie Field – IT infrastructures: talked about what state systems look like. In JV they have IJOS (mgt system), courts have ISTARS, corrections has CIS (new system), H&W has focus (not with substance abuse) – mgt services using CIS at data warehouse to generate reports. Discussed using the Gain assessment tool to put all info together to generate reports, how to talk with other platforms, talks with IT sides to build systems to communicate with each other. Middle part for IT to evaluate – how to get from the start of the process to completion.

John Kirsch – ASAM started in the 1950's, brought together doctors to study alcoholism. Group moved toward "addictionology" in 1982 – for the specialty in medicine, addiction is a disease. In 1989 renamed to American Society for Addictive Medicine. Asamppc2r – patient placement criteria published in 2001 – clinical work of 3-4 organizations. There were 40-50 different sets of criteria to place people in treatment. During 1991-1992, they created new criteria – subjective interpretation by counselors – study has been around a long time – ASAM patient placement criteria 2nd revision. Clients are placed in appropriate levels of care based on 6 dimensions. [See handout]. Recovery environment – family when they got home, situation caused reversion to old habits. Levels of care being funded - Early intervention (up to now funding treatment instead of education or intervention), detox service for adults, residential inpatient. Introduced in 1998 statewide, in 2003 became mandatory for all providers to be trained with ASAM model within 6 months of hire. Bio-cycle social assessment, includes diagnostic impression (for evaluator that is not a doctor), dsm4 diagnostic and statistical manual – bible of mental health field for describing mental health evaluation, assessment summary (assessment, diagnosis then summary). Determine from this information the correct level of care needed. Language of problem list, treatment plans and placement in ASAM terms is based on initial evaluation and then on progress through the program. Adult placement – how to go about describing where a person is to be placed. For example, dimension 1, level 1 has to do with detox and withdrawal – minimal risk for withdrawal syndrome. [See handout]. At each level of the dimensions and levels, the patient has more risks of withdrawal potential, so the higher level of care needed. Physical and mental health also evaluated. [See handout]. Gain I will print this evaluation out.

Jerry Russell – Clarification needed on whether there is a clinical difference on abuse and addiction mentioned in evaluation. John said that "using" is causing major problems in life, vs. not. Sharon said that alcohol abuse is the 1st stage on the path, addiction means there is no going back, and it becomes toxic to your system and you no longer have control over it, but it has control over you. If it's affecting your life (finances, family life, i.e. major life domains) you are in the major abuse phase but can be close to being addicted. Patty – will make sure wording is precise on the definitions. Kathleen pointed out that ASAM doesn't like using the word "abuse".

Brad Alvaro– (IT manager at corrections) Using the CIS system, justice community is building a model to exchange data, global justice examental? To know something like an offender number, standards global justice xmo standards – difficult to collect all into one system sometimes. Recommended looking at a model to define exchange standards to only exchange data needed. Plan to do that with interstate compact – 2 solutions input data using their system or develop a standard to exchange data so no double of work. Process triggers event to send collecting agency or responsible agency to process data.

Debbie Field – Pointed out that the things we can and can't share has already been done with WITS through Maryland (SMART) and will contact person in MD to get info on their system. Juvenile corrections – CMS (can be interfaced with IJOS). Common language in platform for everyone to use. Shane would like current assessment as they enter system to have current information on recommendations to courts, etc. Sharon

would need to share child protection info, mental health info, and substance abuse info to provide judges. Debbie suggested inviting the IT experts at each agency to these meetings to figure out how to bridge the gap of sharing information between systems.

Sharon Harrigfeld – Said that the state of Washington has a system we should look at for flagging connections between offenses and aggregate numbers on reports that child protection is up and so is abuse. To plan appropriately how to help clients. Data pulled from all state agencies or a mechanism to pull all that data. Recommended inviting Ken Star to future meetings to help with discussions on this issue. In the past there have been a series of evaluations that have not been shared between agencies to connect past history on efforts and interventions from various situations in child's life as bad behavior has progressed. Family history of abuse too. Things that have contributed to the abuse problem. Information pooling could tie everything together.

Patty Tobias – Said that court case progress in each county is tracked, including drug court, and her agency would like to participate in actively sharing more info. Intermac was a vehicle, where is it at now?

Debbie Field – Question asked about what WITS was - web infrastructure technology system. John said it was developed to meet needs to bring states up to speed to share information on contracts and grants, all info is open source, all enhancements can be used by other states on system. Jerry – ISP, can add connectivity from ISP system, central repository of info, they are familiar with doing it.

Agenda Item #3 – Gain Assessment Tool Implementation Plan

Debbie Field – There is a meeting on May 2, 2007. A preliminary training lasting about 3 hours from 9 – 12 in the DEQ 1st floor conference room. Will train 32 people to be trainers.

Amy Holly-Priest – Business Psychology Associates (BPA), center staffed 8 to 8, the crisis call center line is 24 hours. Patients are triaged to see if they meet a certain criteria. Pregnant, IV drug user, drug court attendees. Priority population consists of court supervised users, Hispanic population and Native American population. After the patient is triaged, a Gain screening is completed to check the financial and demographic situation to determine eligibility. If the patient is moved to clinical, that screening takes 15-20 minutes. The Gain Q is then implemented. A standard clinical screening follows that takes about 15 minutes and goes through the ASAM. If that is not met, they are recommended to area services, discounted providers and faith based programs to help the ones that don't qualify. A provider can make a recommendation to a higher level of care. Will need to know the amount of money available and number of people waiting since more people will be allowed in at the end of the week. Since there will be an additional 6.5 million from the general fund available as of July 1, there will need to be a decision made on which priority populations to move 1st. Over 5,000 calls received a month to see

if there is availability to get treatment, with 25% of those being repeat callers. Kelly pointed out that we are losing the provider network because of no patients coming in. Amy also stated that there needs to be more timely billing from the providers to better manage the budget and better data to accurately predict how many people are in each level of care. There are currently 675 people on the waiting list, with a 90 day rule for length of stay on the list. Shane said that he thinks his agency can help pick up some of the slack in their individual budget.

> **BPA needs answers on priority populations that will be served, levels of care, which things will continue to be funded and which programs/providers will continue to be funded. The contract ends in June. Kathleen and Bethany will follow up on a 3 month extension of the current contract.**

Patty brought up bills 1142 and 1149, which have no money attached to them, but the patients get helped any way and are considered priority. Kathleen pointed out that if the court ordered treatment uses all the money, others are not getting helped and a supplemental may be needed. Amy Castro said that LSO needs the current number of people in the caseload not being helped to make better estimates for future funding. They need to get the total of what is actually needed, not just what has been done before, since that does not include everyone that gets wait listed. Debbie pointed out that we need to look for providers who would be willing to provide their services at no charge. Sarah Nye said that 1.5 million of the TANF grant goes to early learning in the Executive Office of Family and Children to help some. Amy (BPA) then pointed out that using that block grant could at least get clients started and therefore keep them engaged in the process while on the waiting list. Shane pointed out that you don't need money to manage volunteer services, but that they would need to be trained and that there may be a need to get a funding source for this. Dave brought up the need to find out from the providers details on the capacity level for what they can help do, and need to get details on what is being spent and where in order to assemble data for asking for more budget. Amy Castro said they need a monthly report that details what was spent and what the remaining budget is.

Agenda Item #4 – Wrap Up

Debbie Field – Meeting in LBJ building, room 302 at 9 am, Rep. Clark chairs to start looking at budget. The AG office is looking at what we can and can't share between agencies because of privacy issues. The next meeting needs to start involving IT people and looking more at the systems involved.

Action Items:

1. **RFP**
2. **IT contacts from each agency at meeting(s)**
3. **Intervention**
4. **BPA to look at providing a management report for what is being spent and where, to evaluate future budget requests.**